DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/01/12

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FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445388	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS CENTER OF SPENCER	87 GENERATIONS DRIVE SPENCER, TN 38585

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F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: This requirement is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure a call light was in reach for one (#16) of sixteen residents reviewed. The findings included: Resident# 16 was admitted to the facility on August 25, 2009, with diagnosis of Dementia, non-specified type. Observation on July 16,2012, at 10:15 a.m. revealed resident #16 lying in bed with the call light at the foot of the bed. Review of Call Light/System policy, "...Each resident is provided with a working call light/system within their reach...Be sure the call light is always within easy reach of the resident whether the resident is in or out of bed..." Interview with Licensed Practical Nurse# 2 on July 16, 2012, at 10:15 a.m. in the resident's	F 246	Call light was placed within reach for resident #16 by L.P.N. on 07-16-12. Each resident was checked by assistant director of nursing/ L.P.N. to ensure call lights were within reach following notification of call light out of reach for resident #16 during survey on 07-16-12. All staff in-serviced on call light placement and reach ability on 07-23-12 at 2 p.m. by assistant director of nursing/ L.P.N. Quality assurance nurse/ L.P.N. will ensure call light placement through completion of rounds on 100% of residents weekly by walking through the facility and visually monitoring each call light for one month, beginning on 07-23-12 and random monthly thereafter.	07-23-12

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7-30-12

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 room confirmed the call light was out of reach and has cognitive ability to use the call light.	F 246		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to supervise one resident (#12) of sixteen residents reviewed. The findings included: Resident #12 was admitted to the facility on October 6, 2011, with diagnoses including Dementia with Behavioral Disturbances, Anxiety, Seizures, Alcohol Abuse, and Coronary Artery Disease. Medical record review of a "Resident Smoking Quarterly Assessment" dated April 18, 2012, revealed "...does resident have a history of poor judgment in regards to safety for him/herself or others...yes...resident smoking status...supervised smoker..." Medical record review of a Nurse's Note dated May 26, 2012, revealed "...resident	F 323	The incident occurred on 05-26-12. There was no immediate corrective action for this resident #12. Nursing staff (R.N., L.P.N., and C.N.A.s) and activity staff/ activity director and assistant director will ensure no tobacco products or paraphernalia (including, but not limited to lighters) will be in reach of any resident at any time by placing a small lock on the cigarette box and keeping the cigarettes in a locked storage area in the activity room. The cigarette box will also be locked following the removal of tobacco products and paraphernalia during smoke breaks and the activity director or assistant or nursing staff. R.N., L.P.N. and C.N.A.s). will hold lighter in hand when not in locked box. The Key will be maintained by the activity director, activity assistant and/or nursing staff (R.N., L.P.N. and C.N.A.s). All staff received training on new procedures on 07-23-12 at 2:30 p.m. by director of nursing/ R.N. Safety officer/ dietary manager will monitor smoke breaks weekly for one month beginning on 07-26-12 and once monthly thereafter to ensure cigarette box is locked and lighter or other paraphernalia is secure in hand through visual checks with logged results noted in safety minutes monthly by safety officer/ dietary manager.	07-26-12

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F 323	Continued From page 2 observed...taking cig (cigarette) lighter from pocket...became upset...agitated...many attempts before resident return lighter..." Review of facility policy, "Smoking Policy" last reviewed by the facility on July 13, 2012, revealed "...no resident may possess any tobacco products or paraphernalia...on their being...will be maintained in a secure/locked location..." Interview with the Director of Nursing (DON) on July 17, 2012, at 9:09a.m., in the conference room, confirmed the DON was aware of the incident and the facility did not investigate how the resident got the cigarette lighter out of the activities box. Interview with the Activities Director (AD) on July 17, 2012, at 9:14a.m., in the conference room, confirmed the resident got the cigarette lighter out of the activities box and "can't say for sure how the resident got into the box ...if the box was being carried by someone (staff) resident would not have been able to get into it." Continued interview at that time confirmed it took several attempts over a period of a few minutes before the resident returned the lighter. Interview with the AD on July 18,2012, at 10:35 a.m., in the AD office, confirmed this was the only time this resident attempted to take the lighter.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	see next page for plan of correction for F431	

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F 431	Continued From page 3 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to properly secure a Schedule IV controlled substance in one of three medication carts observed. The findings included:	F 431	The medication packages were reviewed by The director of nursing/ R.N. on 07-21-12. All compromised packages were removed And replaced by pharmacy. Extra storage was provided in each medication cart to accommodate packaging and provide relief to prevent future torn packages. All scheduled/ controlled substances are maintained under double lock and verified by # on medication, medication administration log, and physician orders. All compromised packaging will be returned to pharmacy and/or not accepted upon delivery. When single medications become compromised, the medications will be destroyed by two nurses (R.N., L.P.N.) for verification with signatures and documentation provided on control sheet any multi dose package that becomes compromised will be turned in to the director of nursing/ R.N. and will be destroyed by director of nursing (R.N.) and pharmacy consultant. each nurse (R.N., L.P.N.) received in-service training 07-23-12 through 07-26-12 on compromised medication protocol from director of nursing/ R.N.	07-26-12

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F 431	Continued From page 4 Observation on July 17,2012, at 9:30a.m., in the medication room, revealed a multi-dose card of Lorazepam (benzodiazepine) 1 milligram tablets with the protective foil backing broken on two of the seventeen remaining tablets. Interview with Licensed Practical Nurse (LPN) #1 on July 17, 2012 at 9:30a.m., in the medication room, confirmed the foil backing was broken and "this happens often and we are to place a piece of tape over torn foil when this occurs." Continued interview confirmed the packaging was compromised and there was the possibility the medication could be removed. Interview with the Director of Nursing (DON) on July 17, 2012, at 9:50a.m., in the medication room, confirmed the "staff is to place a piece of tape over torn foil" on controlled medications and by using this system the "medications could be easily taken or substituted." Continued interview confirmed this occurs often and this "is a definite problem." Review of the Tennessee Pharmacy Laws 2011 Edition Rule 1140-03-.08 Repackaging revealed "...(1) Any repackaging of prescription drugs...must be supervised and controlled by a pharmacist..." Continued review of Rule 1140-4-.10 Unused Drugs, Devices, and Related Materials revealed "...defective...containers with worn...shall be returned to the pharmacy practice site for proper disposition..."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	see next page for plan of correction for F441	

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F 441	Continued From page 5 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	The C.N.A.s were re-educated on infection Control practices and ice pass procedures on 07-23-12 by the assistant director of nursing/ L.P.N. The director of nursing/R.N. re-educated the R.N.s and L.P.N.s on infection control policy related to resident ice pass and procedural oversight. The safety scoop and guardian system were purchased on 07-26-12 to provide assistance for safe practice during resident ice pass and the quality assurance nurse/ L.P.N. will conduct weekly inspections to ensure nursing staff comply with policy and procedures during resident ice pass for one month and once monthly at random thereafter.	07-26-12

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F 441	Continued From page 6 This requirement is not met as evidenced by: Based on observation, facility policy review, and interviews, the facility failed to ensure sanitation of ice pass for one of one hall. The findings included: Observation of ice pass on hall100 on July 16, 2012, at 2:20p.m. revealed two Certified Nurse Assistants (CNA) brought water pitchers from resident rooms, used a scoop that was stored in the ice cooler to fill the resident's ice pitchers; and filled the pitchers with ice, allowing the overflow to go into the clean cooler of ice contaminating the ice cooler. Continued observation revealed the CNAs did not wash hands between handling water pitchers and one CNA used hands to push hair away from own face and continued water pass without washing hands. Review of Water/Distributing Fresh Water to Residents policy reveals "...replace ice scoop in covered container...to avoid contamination...wash hands...holding water pitcher over the towel on the cart...avoid contaminating scoop..." Interview with CNA's #1 and #2 on July 16, 2012, in hall 100 at 2:20 p.m., confirmed the CNA was trained on ice pass to not store the scoop in the ice container, to wash hands between residents, to not hold water pitcher over the ice cooler, and to wash hands between touching resident's pitchers to avoid contamination of ice water, and after touching own hair. Interview with Assistant Director of Nursing (ADON) on July 17,2012 in the nursing station at	F 441		

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F 441	Continued From page 7 2:00 p.m. confirmed the CNAs were trained per policy to pass ice and the CNAs failed to implement the facility Infection Control Policy to minimize the risk of cross contamination.	F 441		
F 500 SS=F	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and a review of facility written agreements, the facility failed to obtain written agreements to provide physical, occupational, and speech therapy for residents as needed. The findings included: Interview with the Administrator on July 17, 2012, at 3:00p.m., in the Administrator's office,	F 500	There were no residents affected by the practice. Each resident requiring needed therapies was provided the service through an agency with no contract. A contract for physical, occupational, and speech therapy was initiated with Friendship Home Health Agency by Administrator on 07-25-12. The administrator will be responsible for ensuring continuation of written agreement for physical, occupational, and speech therapy services via daily communication with the director of nursing/ R.N. who will notify the administrator of needed services. The quality assurance nurse/ L.P.N. will review contracts with departmental leaders annually to ensure professional services are available and provided in a timely manner.	07-25-12

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F 500	Continued From page 8 revealed when a resident was in need of specialized rehabilitative services, the resident was transported to an outpatient therapy center affiliated with a community hospital approximately twenty miles from the facility. Continued interview with the Administrator revealed the facility had a transfer agreement with the community hospital, and this agreement included the provision of specialized rehabilitative services to facility residents. Review of the transfer agreement between the facility and the community hospital revealed the transfer agreement did not include provision for physical, occupational, and speech therapies to facility residents. Interview with the Administrator on July 18, 2012, at 1:00 p.m., in the Administrator's office, confirmed the facility failed to obtain written agreements for the provision of specialized rehabilitative services.	F 500		
F 514 SS=D	483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	see next page for plan of correction for F514	

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F 514	Continued From page 9 This REQUIREMENT is not met as evidenced by: This requirement was not met as evidenced by: Based on medical record review, and interviews, the facility failed to ensure a complete, accurate and accessible record for one (#15) of sixteen residents reviewed. The findings included: Medical record review revealed resident #15 was admitted to the facility on March 21, 2011 with a diagnosis of fractured left hip. Continued medical record review revealed two physical therapy progress notes dated July 18, 2012, and October 27, 2011 found in the overflo chart. Continued medical record review revealed no further physical therapy documentation regarding an evaluation for physical therapy, progress notes, or final disposition of physical therapy status. Interview with Administrator on July 18,2012, at 2:55p.m., in the conference room confirmed the facility's medical record did not contain a physical therapy evaluation or progress notes.	F 514	Records were obtained for resident #15 on 07-23-12 by medical records nurse/ L.P.N. The medical records nurse/ L.P.N. completed a chart audit at 100% of active resident charts and obtained all records needed. The medical records nurse/L.P.N. will ensure each resident has a complete record and will be responsible for obtaining records from outside service sources and ensuring accessibility. The medical records nurse/L.P.N. will communicate with the director of nursing/ R.N. any records requested and not received for instruction and further action steps. A progress note will be entered into the resident chart reflecting attempts to access information by nursing staff (R.N., L.P.N.) The medical records nurse/ L.P.N. will include in monthly audits of resident charts a list of records that need obtained and a copy of the request to be received and reviewed by the director of nursing/ R.N. for monthly monitoring.	07-23-12